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In The

Supreme Court of the United States

OCTOBER TERM, 1985

JOHN MARTORANO,

Petitioner,

-vs-

UNITED STATES OF AMERICA,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE NEW JERSEY SUPREME COURT

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QUESTIONS PRESENTED

1. Whether 18 U.S.C.A. §1027 requires proof of a mere "failure to disclose" as determined by the Third Circuit Court of Appeals in **United States v. Martorano, 704 F.2d 63, 66 (3 cir. 1985).**, or a "voluntary conscious failure to disclose without ground for believing that such non-disclosure is lawful" as determined by the Sxith Circuit in **United States v. S and Vee Cartage Co. Inc., 704 F.2d 914, 919 (6 Cir. 1983)** and the Second Circuit in **United States v. Tolkow, 532 F.2d 853, 858 (2 Cir. 1976).**?

2. Whether the Government Adduced Sufficient Evidence to Support the §1027 Conviction Of Petitioner?

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No.

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1985

JOHN MARTORANO

V.

UNITED STATES

PETITION FOR A WRIT OF CERTIORARI
TO THE THIRD CIRCUIT COURT OF APPEALS

Petitioner prays that a writ of certiorari issue to review the judgment order of the Third Circuit Cour of Appeals entered in this proceeding on July 8, 1984.

OPINIONS BELOW

The opinion of the Third Circuit Court of Appeals is reported at 767 F.2d 63 (3 Cir. 1985).

JURISDICTION

The jurisdiction of the Supreme Court to review the final judgment of the third Circuit Court of Appeals is based upon 28 U.S.C.A. 1254 (1).

CONSTITUTIONAL PROVISIONS INVOLVED

Petitioner seeks review of issues of law arising under the Fifth, Sixth and Fourteenth Amendments to the United States Constitution.

STATEMENT OF THE CASE

I.

Introduction

This petition arises from petitioner Martorano's conviction of making false statements in a document required to be maintained by the Employment Retirement Income Security Act of 1974 (hereinafter "ERISA"). Uttering a false statement in such documents is proscribed within 18 U.S.C.A. §1027. The offense resulting in petitioner's conviction was embodied in Count Three of a four count indictment. At the outset, it should be emphasized that the jury acquitted petitioner on Count Two which also charged a §1027 violation. In fact, Count Two related to a utilization report prepared in an identical fashion to the utilization

report at issue in Count Three. No false statement was uttered within either utilization report. Therefore, the same verdict should have been rendered as to each. Individuals undertaking a less than meticulous evaluation of the reports may have misinterpreted the format as detailing actual costs as opposed to "relative dollar value." Any such confusion would be perplexing because the documents clearly listed the contents as reporting "value."

The alleged §1027 violations were not the primary focus of the prosecution. The thrust of the indictment was an alleged mail fraud scheme and theft from a union welfare fund. The jury acquitted petitioner of both of those offenses, thereby finding that petitioner neither perpetrated a fraud nor a theft. The indictment in practical effect was a theoretical condemnation of petitioner's business and accounting practices, some of which were unorthodox but none of which were criminal.

The indictment focused upon petitioner's business conduct subsequent to entry into a contract to provide services to the Health and Welfare Fund of Local 837 of the Industrial Workers Union (hereinafter

"The Fund"). Petitioner contracted with the Fund to provide outpatient medical services to Local 837 members in return for a premium of $8.50 per month for each member. The conduct primarily at issue in the indictment related to the nature and substance of a request which petitioner made for an increase in premiums. Petitioner proffered such a request as part of a renewal of the original contract. An increase to $10.00 per member each month was sought.

When the increase was requested, it was generally represented that costs were rising and as a result petitioner's company was not realizing substantial profits. A new contract was agreed to on the basis of the quality of the services provided by petitioner's company. The quality and value of the services were superior. Comparable services were not available for a similar premium. Utilization reports submitted to Fund trustees after renewal of the contract indicated that Local 837 members benefited greatly from the program and that the Fund received substantial value for its premiums. The trustees claimed at trial that they misinterpreted value calculations within the reports as representing costs. However, it is

clear that the reports did not to any degree affect the quality of the services or the trustees' decisions to enter the contract. The program offered by petitioner was the best and least expensive. The reports merely did not reveal petitioner's actual profits.

Thereafter, a Pennsylvania state investigative agency informed the trustees that petitioner profited substantially from the contract with the Fund. However, it was not understood by the Fund trustees that the corporate structure of petitioner's business was such that profits from the Local 837 contract were diminished by a failing ambulance service. The ambulance service's losses offset petitioner's gains. The trustees requested that petitioner disclose his actual costs and profit . Acting on the advice of counsel, petitioner refused to divulge his actual costs on the ground that he had no legal obligation to do so. Counsel advised petitioner that he need provide only the dollar value of services to the trustees. Therefore, petitioner did not modify nor supplement the previously submitted utilization reports.

This conduct was unsuccessfully alleged by the government to be a mail fraud scheme which resulted in a theft of fund assets. The government's theory was that petitioner purloined the increased premium. The nature of the jury's verdicts is such that this petition is restricted to an evaluation of whether adequate evidence was adduced to underpin a conviction on Count Three. A review of the evidence establishes that this Court must enter a judgment of acquittal or at a minimum reverse the conviction. Petitioner neither made a false statement nor "knowingly concealed" any fact "the disclosure of which is required by [ERISA]." 18 U.S.C.A. §1027.

a. Procedrual History

Eastern District of Pennsylvania Indictment No. 84-00032 charged petitioner John Martorano with: mail fraud in violation of 18 U.S.C.A. §1027 (Counts Two and Three) and theft from an employee benefit plan or connected fund in violation of 18 U.S.C.A. §664 (Count Four). Petitoner entered a plea of not guilty to each offense set forth in the indictment.

Trial commenced on June 12, 1984 before the Honorable Raymond J. Broderick, U.S.D.J. and a jury. On June 26, 1984, following an 11-day trial, petitioner was acquitted on Counts One, Two and Four and convicted on Count Three (making false statements in a document required to be maintained by ERISA). Thereafter, on September 5, 1984, petitioner appeared before Judge Broderick for sentencing. Judge Broderick imposed a sentence of three years imprisonment and a $10,000 fine upon petitioner. On July 8, 1985 the Third Circuit affirmed.

I.

The Government's Proofs

a. Howard Bucher - The Fund Administrator

i.

Bucher's General Responsibilities

Bucher has been employed as the administrator of the Fund since October of 1966. Local 837 has approximately 2,000 members. Bucher described his responsibilities at trial. He stated:

> I primarily act upon claims that are submitted to our office...We pay sick pay, we pay doctor bills, we would pay hospital bills...We are in receipt of contributions

> made by the employers and we make deposits...to the funds for the employer...all records pertaining to the health fund are in our office....I am employed by the health and welfare fund [and am] answerable to the board of trustees of the health and welfare fund, not to the offiers of Local 837.

The trustees make decisions as to entry into particular contracts and other complicated decisions, including whether to select a particular benefit provider. Bucher makes "routine day to day decisions." On an annual basis, Bucher prepares and files a report with the Department of Labor and Internal Revenue Service.

ii.

The Contracts Entered Into Between The Fund And AMMA Health Center, Inc.

In September of 1978, the Fund entered into a two-year contract with AMMA Health Center, Inc. (hereinafter "AMMA"). AMMA agreed to provide outpatient medical services in return for a premium of $8.50 each month for each member of Local 837. In

December of 1978, petitioner became the administrator and principal owner of AMMA. In April of 1980, he requested an increase in the premiums paid to AMMA. The request was in the form of a letter addressed to Bucher. The request was purportedly predicated upon an increase in costs experienced by AMMA. A new five-year agreement was drafted which increased the premium to $10.00. The agreement also incorporated a cost of living index increase. Bucher transmitted letters to each of the trustees advising them of the new agreement.

Trustees Ann Hill and John Price expressed a reluctance to sign the new agreement. Information was provided to Hill and Price indicating that the AMMA proposal was competitive with other programs and indeed superior in flexibility and cost. (T2.32-18 to 35A-6). The trustees approved the new agreement with AMMA" to be effective for October of 1980."

iii.

The Requests That AMMA Provide Utilization Reports And The Controversy Which Developed

Bucher requested that petitioner provide utilization reports to the Fund. Such reports detail the frequency with which Local 837 members utilized AMMA services. Reports were forwarded to Bucher on February 17, 1981 and April 9, 1981. The February 17, 1981 report embodied information relating to the period between January and December of 1980. AMMA received premiums in the amount of $235,707 during this period. The report reflected an annual net profit to AMMA of $4,817. This amount reflected a deduction from the amount of premiums of the value of the services provided to Local 837 members and the costs of administration. Bucher testified at trial that he was of the view that the "relative dollar value" of services category was intended to reflect the actual cost to AMMA of providing services. Bucher forwarded the February 17, 1981 utilization report to trustees with a cover letter stating that "[the] high benefit utilization more than justifies our participation in this program."

Bucher requested a similar report for the periods "of October 1978 through December 1978 and January 1979 through December of 1979." A report relating to these periods was submitted on April 9, 1981.

This report was drafted in the same format as the previously submitted utilization report. Premiums in the amount of $234,623.50 were paid to AMMA for the period between January 1979 and December 1979. The annual net profit for that period was $39,305.21.

During the period in which the utilization reports were transmitted, the fund was under investigation by a state agency. That agency's investigation prompted the trustees to seek an accounting of AMMA actual profits. A trustees meeting was convened and petitioner was asked to attend. Petitioner appeared with his attorney and another adviser. Bucher described the meeting. He stated:

> We asked [petitioner] some direct questions regarding his profits in his business and some questions regarding the utilization reports that were presented to us. And his response was, frankly, that his profits were none of our business, and the utilization reports were a summary of what the benefits would have cost...It was a calculation that is provided that estimates how much a physician's visit generally costs...generally for the

area...it was not actual costs...they were drawn from a Blue Shield summarization.

Petitioner refused to provide his actual costs and the Fund terminated the contract. In September of 1981, the Fund entered into a new contract with Health Affairs, Inc.

iv.

Bucher's General Comments Respecting The Services Provided By AMMA

Bucher testified that AMMA was the best program available when the Fund entered into the contract and was the least expensive. Comparable programs would cost "$35 to $120 a month for a family." These costs were "prohibitive." When the Fund entered the contracts with AMMA, there was no discussion concerning the actual costs to AMMA or its expected profits. Moreover, the costs to AMMA were of no concern to the Fund. The Fund focused upon the $8.50 premium. Similarly, when the contract was negotiated, no mention was made of a "need to make

periodic reports." Moreover, the company which replaced AMMA has at no time provided a cost or value breakdown to the Fund. Bucher received much praise from the members and several trustees because of the services provided by AMMA. Moreover, when AMMA requested the $1.50 increase, it was still the lowest priced program. It "couldn't be beat."

b. The Trustees

John Price was a Fund trustee during the period at issue. Local 837 was highly pleased with the services provided by AMMA. Price believed that the utilization reports reflected costs. Price claimed that he would not have voted for renewal of the contract if he was aware that actual costs were lower than value. However, he agreed that when he approved the contract, "[he] didn't know whether AMMA was making money or not." This is because the utilization reports were submitted subsequent to approval of the new contract.

Ann Hill was also a trustee of the Fund during the period at issue. Her objection to the modified contract with an increase in premiums was predicated upon a desire for "outside bids for the

trustees to review." Hill approved the new contract subsequent to a review of comparable programs. Hill also considered a letter written to her by petitioner which indicated that his profits were dwindling due to rising costs. Nonetheless, her primary purpose for approving the new contract was that AMMA was the lowest priced program even considering an increase. She too believed that the value of services outlined in the utilization reports reflected costs. Of course the reports did not impact on her decision to approve the new contract, because she received the reports subsequent thereto.

Avrum Cohen was a Fund trustee during the applicable period. Cohen approved the increase because it was recommended by Bucher. When he subsequently received utilization reports, he interpreted relative dollar values as reflecting actual costs.

Trustee Stanley Neiman approved the second contract with AMMA "as suggested by [Bucher]". He testified at trial that when he subsequently reviewed the utilization reports, he defined relative dollar values as being "[what] AMMA paid out." He would have "explored the contract further" had he known that value

as opposed to costs was reflected in the report. Neiman conceded that the AMMA services were "highly recommended" both by Bucher and the Fund's lawyer.

Trustee Harold Jacoby interpreted the term "dollar value of services" as "money outlaid by AMMA." He would have "questioned" the previously entered into contract had he known AMMA was generating a particular level of profits.

c. Maurice Abrams - The Fund Attorney

Abrams has represented the Fund since 1964. He participated in the request that AMMA provide utilization reports. Abrams stated:

> We required this information to complete the government filing forms which are required by a Fund under ERISA, a form ...designated as a 5500 form...

Upon receipt of the reports, Abrams assumed the view that "utilization justified continuing this benefit." Thereafter, a question arose with respect to whether the reports reflected "actual monies spent by AMMA to service the participants." A meeting was

convened by the trustees on July 14, 1981 and petitioner's presence was requested. Abrams described his participation in the meeting. He stated:

> The trustees had asked me to present their source of displeasure to [petitioner] which I did. Mr. Della Guardia, his attorney, [petitioner] and Mr. De Caro were waiting in my waiting room until the trustees had decided just how to approach this problem, and we then invited these gentlemen in. I informed them that we had some problem with - with these exhibits, that we had reason to believe that these were not the actual figures expended by AMMA in servicing the participants. Mr. Della Guardia, speaking for [petitioner] replied that the actual figures were not our concern, that we had a contract with AMMA wherein we paid the sum of $10 a month per member for which services were to be provided on an outpatient basis.
>
> Those services were being provided, and the actual cost to AMMA was not the business of the trustees. I responded by pointing out to Mr. Della Guardia that, among other reasons, we needed

> the information to complete the 5500 form which has a specific schedule covering this kind of a service provider, and that, in addition, we had just agreed with [petitioner] to a five-year agreement which contained a cost of living increase, and the trustees had to know on what that cost of living increase would be based, and that we wanted the actual figures which were not given to us.
>
> Mr. Della Guardia indicated that he would not advise his client to make those available to us, and the meeting sort of ended on that note.

Thereafter, the trustees requested by letter "a monthly statement from AMMA indicating the number of participants who received services, the names of the doctors who provided such services, together with the actual cost of such services." Petitioner responded by letter that the Fund was not entitled to that information. This response prompted the trustees to discontinue the Fund's contractual relationship with AMMA.

d. David B. Byruch and Alan Roomberg - Accountants Previously Retained by AMMA

Byruch functioned as the accountant for AMMA and Med-Bus (an ambulance service owned and operated by petitioner) during a portion of the period at issue. Byruch recommended that petitioner form Advance Project Corp. as a holding company for AMMA and Med-Bus. A holding company "holds the stock of both companies. Byruch explained the basis for his recommendation. He stated:

> There was an accounting need, as well as a tax need...you want to put the two companies together for tax purposes, and by doing that we would form a consolidated group....to offset the profits from one and the losses against the other...AMMA was having a profit and Med-Bus was showing a loss.

But for the holding company procedure, AMMA would had to have shown a profit for tax purposes and Med-Bus a loss. Byruch characterized this as a normal practice for state tax purposes.

Roonberg was retained by petitioner in March of 1980 for the purpose of providing accounting services. He replaced Byruch. He prepared a tax return for Advance Project, AMMA and Med-Bus for the year

ending October 31, 1982. Roomberg also transferred management fees from AMMA to Med-Bus as an accounting device designed to minimize tax exposure. Petitioner at all times instructed Roomberg "let's be certain we paid all the proper taxes that we should pay."

e. Roseann DiGrazio Averill - The Preparer Of the Utilization Reports

Averill was previously employed by AMMA and Med-Bus. Averill's AMMA duties included traveling to "Broad Street Hospital...and to satellite offices...[to] take down their patient information, name, address, etc., record it and page [the] doctor." Averill would also "do billings from the different doctors, broke them down, paid them."

Averill also prepared the utilization reports requested by the Fund. As opposed to setting forth actual costs to AMMA of office visits, Averill placed a value on services by reference to Blue Cross and Blue Shield schedules. Averill inserted the amount" Blue Cross and Blue Shield would have gotten." Averill stated that this formula was "what Mr. Bucher expected us to do." Bucher "pressured [Averill] to get it done"

in several discussions. Subsequent to her completion of the reports, Averill advised petitioner that the reports represented "correct and accurate figures according to [her] records."

f. Richard Geibel - The Government's ERISA Expert

Geibel is chief of the Office of Pension and Welfare Benefit Programs and the Division of Reporting Enforcement. In the context of his agency's responsibilities, Geibel claimed that "reports..submitted by service providers...are essential...to determine just what types of services the participants were receiving." Simply put, Geibel testified that his agency reviews "how the premium money was spent..in providing benefits." The 5500 forms filed by Bucher and the trustees did not indicate that the Fund provided any outpatient medical benefits.

The 5500 form contains a warning to its preparer that it must be true, complete and accurate or the preparer is exposed to a perjury prosecution. This provision is printed directly above the signature line. No effort was made by Geibel's agency to sanction Bucher for filing incomplete 5500 forms. No advisement is provided by any agency to a service

provider to the effect that particular information must be provided to plan administrators. Giebel testified that service providers should have independent knowledge of their responsibility to provide particular information to plan administrators. Many service providers have resisted providing certain information. In those cases, plan administrators have requested that Giebel's agency intervene. No such intervention request was made by the Fund in an effort to gain additional information from petitioner . Bucher opted instead to file incomplete 5500 forms.

II.

The Evidence Presented
By Petitioner

a. James DeCaro- An Advisor To Petitioner

DeCaro has been employed in the medical service provider industry for the past decade. He was introduced to petitioner in 1978. The purpose of the introduction was to facilitate a discussion of combining a dental program with an outpatient benefit program. When petitioner experienced financial difficulties with AMMA/Med-Bus, he sought DeCaro's advice. DeCaro advised him that the Fund's premium payments were

too low and an increase should be requested. He further advised petitioner that "you can get hurt, especially if there's some outbreak of disease, and everybody starts running to the doctor, you are going to get into some type of trouble."

Petitioner also sought DeCaro's aid in connection with preparation of the utilization reports. DeCara advised Averill to calculate administrative costs as "between 13 and 18%." DeCaro informed Averill that "this is an honest fee." DeCaro also attended the July 1981 trustees' meeting. At the meeting, in response to an inquiry from petitioner, Bucher acknowledged that he requested that value as opposed to costs be set forth in the utilization reports.

b. Joseph L. Della Guardia - Petitioner's Attorney

Petitioner sought legal advice from Della Guardia respecting his reporting responsibilities as a service provider to the Fund. Della Guardia also accompanied petitioner to the July 1981 trustees' meeting. Della Guardia informed the trustees that "costs were not required to be given under the

contract." Della Guardia previously advised petitioner that "under the contract, they were entitled to...value of services given to the membership."

Bucher acknowledged at the meeting that he instructed petitioner to provide value. Abrams, the Fund attorney, stated that "cost figures were required by ERISA." Della Guardia disagreed on the ground that "AMMA wasn't an insurance company."

c. Robert H. Dobson - An Actuarial Expert

Dobson is an actuarial expert who has "specialized in health programs since the mid-70's." Dobson testified that service providers like AMMA ordinarily set aside a substantial reserve to protect against the risk of utilization beyond that covered by premiums in a given year. "It would not be "unusual for [a reserve] to account in excess of...half of a year's fee income. Dobson further testified that statistical data indicates that an average family expends $135.00 per year for medical care.

Dobson also reviewed the utilization report submitted by AMMA and understood that the reports listed value as opposed to costs. He stated:

> [The] documents relate very clearly to value..The column readings, dollar value of office visits, dollar value of lab and x-ray...

With respect to administrative costs, Dobson testified that "carriers typically will use an expense charge rather than tallying up the exact expenses." In this context, Dobson stated "14% is certainly reasonable in industry standards."

With respect to the net profit listed on the reports, Dobson stated "the fact that its labeled dollar value...implies that the actual costs paid or amount paid was different from that." He stated further:

> Many Blue Cross plans have discounts with hospitals. For example, they frequently would report on the total value or total charges to make their data comparable to a carrier that didn't have a discount.

In this regard, "fee schedules like Plan C Blue-Cross/Blue Shield [is] used to set value or set the industry standards in the health care field."

On the basis of the foregoing evidence, petitioner was acquitted of mail fraud; theft from the Fund and making a false statement in the February 17, 1981 utilization report. Notwithstanding that the April 9, 1981 was identical to the February report, petitioner was convicted of making a false statement within it. The Court of Appeals affirmed. This petition for certiorari follows.

REASONS FOR GRANTING THE WRIT

POINT I

Certiorari Should Be Granted Both To Firmly Establish The Rule of Law That 18 U.S.C.A. §1027 Requires Proof Of A Knowing and Conscious Failure To Disclose And To Generally Free Petitioner Of A Conviction Which Is Not Supported By Sufficient Evidence

Petitioner Martorano was convicted of the §1027 violation set forth in Count Three of the indictment. That count pertains to a utilization report mailed to the Fund on April 9, 1981. As is pertinent hereto, Count Three states:

> This report purported to provide monthly figures for the number of office visits, the dollar value of office visits, the dollar value of labboratory and x-ray services and the total dollar value of services provided...total dollar value of services rendered (for both 1978 and 1979), cost of administration and an annual net profit figures (for both 1978 and 1979) that was derived by subtracting total dollar

value of services rendered and cost of administration from total premiums paid.

The April 9, 1981 utilization report was a document that [the Fund] was required by Title I of ERISA to keep and maintain as part of its records, and was a document required to provide necessary basic information and data from which annual reports of [the Fund]...could be verified, explained, clarified, and checked for accuracy and completeness.

* * *

...[Petitioner] through the utilization report...made false statements and representations of fact, knowing them to be false, and knowingly concealed, covered up and failed to disclose facts...in that the..report knowingly and falsely misrepresented the annual profit of AMMA and knowingly concealed, covered up and failed to disclose the actual nature and amounts of AMMA's expenditures of premiums paid by [the Fund] to AMMA.

Count Three is identical to Count Two. The single distinction is that Count Two relates to a utilization report submitted to the Fund on February 11, 1981. Both reports were prepared in the same fashion. Petitioner was acquitted of the §1027 violation set forth in Count Two.

The jury correctly perceived that insufficient evidence was adduced to convict petitioner of the §1027 violation set forth in Count Two. Because the factual and legal principles governing the jury's consideration of Count Two are indistinguishable from those applicable to Count Three, it is clear that a misconception of the law induced a verdict of guilty on Count Three. However at the outset we acknowledge that the inconsistency in the verdicts will not be considered by this Court as a ground for relief. United States v. Powell, ___U.S.___, 83 L.Ed. 2d 461 (1984).

In any event, it is nonetheless clear that the jury's verdict is not supported by sufficient evidence. Specifically, petitioner did not falsify any information nor did he knowingly conceal information. Viewed at Acting on the advice of counsel, petitioner declined to disclose particular information on the ground that he

was not legally bound to do so. Thus, he had no intent to conceal information in violation of a statutory duty. Absent a showing that §1027 is a strict liability offense, the government did not prove its commission herein. As will be discussed infra, the Third Circuit erroneously adopted a standard that in effect makes §1027 a strict liability offense in this circuit. A mere "failure to disclose" is sufficient according to that Court. In contrast, the Second and Sixth circuits require a "voluntary and conscious failure to disclose". This Court must resolve the conflict between these circuits. The present status of the law is that individuals may participate in certain conduct with impunity in the Second and sixth circuits which is criminal in the Third Circuit.

i.

The Proofs

a. The Utilization Reports

The April 9, 1981 utilization report contains a summary of claims activity for eligible members of Local 837 for the period of October 1978 through December 1978 and January 1979 through December 1979." Five columns are set forth within the report

with corresponding information listed below. The columns are captioned: month; number of office visits; dollar value of office visits; dollar value of lab and x-ray and total dollar value. Thereafter, an average dollar value is established per claim and a dollar value of services is deducted from the total premiums paid. The report is then completed by deducting a cost of administration from that figure. The bottom line is captioned annual net profit. The word cost is utilized only with respect to the "administration" aspect of the report. This report follows the same format of the report submitted on February 17, 1981. That report was the subject of Count Two. The February 17, 1981 report established the procedure that the cost of administration figure was calculated as 14% and bore no relationship to actual expenses. The predominant descriptive word utilized throughout both reports is value.

b. Consideration Of The Reports By The Fund Trustees

Within a matter of months subsequent to submission of the utilization reports, a trustees' meeting was convened to discuss the format selected by AMMA.

The trustees indicated at the meeting that they were aware that the figures reflected in the reports were not costs. Petitioner was informed that the trustees desired a breakdown of costs. Petitioner acknowledged that value as opposed to costs were reflected therein. Through his attorney, petitioner further stated that costs were not as a matter of law required to be disclosed. Amongst other options, the Fund could have sought to compel disclosure by virtue of a declaratory judgment or other civil action. Petitioner refused to disclose the information due to a legitimate disagreement as to his obligation. According to the government's ERISA expert, Geibel, such disputes were common. Geibel testified that his agency was often enlisted to intervene in these controversies. However, in the instant case, this administrative controversy resulted in criminal prosecution of petitioner .

ii.

The Law As To Challenges To The Sufficiency Of Evidence

When the sufficiency of evidence is challenged in a criminal case, the standard of review is whether a jury could reasonably infer from the evidence that the defendant is guilty of the offense with which he is charged beyond a reasonable doubt. United States v. Martorano, 709 F.2d 863, 866 (3 cir. 1983), cert. den. 104 S.Ct. 486 (1983). To uphold the verdict, a reviewing court must find that the prosecution adduced substantial evidence of commission of each element of the offense. United States v. Camiel, 689 F.2d 31, 36 (3 Cir. 1982); United States v. Irizarry, 673 F.2d 554, 560 (3 Cir. 1982). Simply put, to sustain the instant conviction, viewing the evidence in the light most favorable to the government, together with all reasonable inferences to be drawn, this Court must find that the verdict is supported by substantial evidence that petitioner's conduct constituted a completed §1027 violation. United States v. Storm, 671 F.2d 749, 751 (3 Cir. 1982), cert. den. 459 U.S. 842 (1982). Cf. United States v. Shoup, 608 F.2d 950 (3 Cir. 1979);

iii.

The Law Relating To §1027

18 U.S.C.A. §1027 states inter alia:

> Whoever, in any document required by Title I of [E.R.I.S.A.] to be published or kept as part of records of any employee welfare benefit plan...or certified to the administrator of any such plan, makes any false statement...or knowingly conceals...or fails to disclose any fact the disclosure of which is required by such title or is necessary to verify, explain, clarify or check for accuracy and completeness any report required by such title to be published or any information required by such title to be certified, shall be [found guilty].

The most recent decision interpreting §1027, **United States v. S and Vee Cartage Co. Inc., 714 F.2d 914, 919 (6 Cir. 1983)**, states that the statute imposes criminal liability upon one who makes "any false statement or representation of fact, knowing it to be false, or knowingly conceals, covers up, or fails to disclose any fact the disclosure of which is required by ERISA." The term "knowingly" requires proof of a voluntary and conscious failure to disclose without ground for believing that such non-disclosure is lawful, or with reckless disregard for whether or not it is lawful."

United States v. S and Vee Cartage Co., Inc., supra at 919; United States v. Tolkow, 532 F.2d 853, 858 (2 Cir. 1976) (emphasis added).

In S and Vee Cartage, supra, the Court also considered to what persons the statute extends criminal responsibility. The statute refers to "whoever." 18 U.S.C.A. §1027. Reported opinions have affirmed convictions of trustees, United States v. Tolkow, supra; union officers, United States v. Santiago, 528 F.2d 1130 (2 cir. 1976); a salaried supervisor of an employee benefit fund; United States v. McCrae, 344 F.Supp. 942 (E.D.Pa. 1972) and employers, S and Vee Cartage, supra. No reported opinion prior to the Third Circuits decision herein held that service providers are within the ambit of §1027. See, 34 A.L.R Fed 846.

The nature of the violations heretofore affirmed is also instructive. In S and Vee Cartage, supra, an employer understated the number of its eligible employees and the amount of contributions due. The employer also identified two individuals as eligible employees, who were not eligible. 704 F.2d supra at 915-916. In Tolkow, a trustee failed to disclose a party-in-interest loan. Party-in-interest loans are loans

made by a union pension or trust fund to businesses in which fund officials have a financial interest. 532 F.2d supra at 855. The defendant therein sought to insulate himself from liability by virtue of proof that an accountant prepared the report. That defense was unsuccessful only because the defendant had not disclosed all material facts to the accountant. Id. In Santiago, the fund administrator substantially understated the amount of employee contributions to the Welfare Fund, in circumstances where contributions were diverted to union coffers. 528 F.2d supra at 1134. In McCrae, a salaried plan supervisor loaned a fund certificate of deposit for use as collateral and embezzled a fee paid for its use. Unlike those violations, petitioner did not receive any illegal benefit. This fact is probative of guilt. See United States v. Tolkow, supra.

iv.

The Opinion of the Third Circuit Herein

The Third Circuit affirmed petitioner's conviction subsequent to review of our claim that insufficient evidence of either a false statement or failure to disclose evidence was adduced. The error of

the Third Circuit stemmed from its incomplete analysis that "a general intent (a failure to disclose) (rather than a specific intent (a failure to disclose knowing that such failure violates a statutory requirement) is all that is required to prove a violation of §1027". United States v. Martorano, 767 F.2d 63, 66 (3 Cir. 1985). The Third Circuit failed to evaluate petitioner's claim in light of whether the government proved a "voluntary and conscious failure to disclose without ground for believing that such non-disclosure is lawful." United States v. S and Vee Cartage Co. Inc., supra at 919. The ruling of the Third Circuit, viz., is that a mere failure to disclose is sufficient, is in direct contrast to the Sixth Circuit opinion in S and Vee Cartage, supra, and Second Circuit opinion in United States v. Tolkow, supra. It is important to note that in fashioning its opinion the Third Circuit pruported to rely on S and Vee Cartage and Tolkow. However, neither of those cases rested upon the simplistic analysis of intent undertaken by the Third Circuit.

A. <u>There Was No Evidence Adduced At Trial Establishing That Petitioner Incorporated False Information Into The April 9, 1981 Utilization Report</u>

There are two means through which a §1027 violation may be committed. The first means is by virtue of false statements or misrepresentations within a covered document. The second means is a knowing concealment or failure to disclose with reference to a covered fact. 18 U.S.C.A. §1027. The lack of evidence respecting knowing concealment is discussed in **Part B, infra.** Clearly, the government has not demonstrated that either utilization report contained a false statement or misrepresentation. Therefore, the trial court erred in denying petitioner's motion for a judgment of acquittal at the end of the government's case and thereafter at the conclusion of trial.

A plainly defined element of §1027 is that the preparer of a document must be found to have knowledge that a statement or representation of fact is false. The element of knowledge is absolutely essential to any fraud-related concept. False statements have no vitality nor purpose, absent some underlying motivation. Thus, knowledge tends to be probative of motivation. Where no motivation exists, the conduct is at best careless. Ordinarily, the criminal law does not punish careless conduct. More specifically, §1027 punishes

neither careless nor negligent conduct. Absent proof of knowledge and a deceitful purpose, §1027 is inapplicable. This is consistent with the general treatment of fraud-related behavior. See, Shores v. Sklar, 647 F.2d 462 (5 Cir. 1981); Glovatorium, Inc. v. NCR Corp., 684 F.2d 658 (9 Cir. 1982); Banco National De La Vivienda v. Couper, 680 F.2d 727 (11 Cir. 1982). In short, "scienter" is the essence of fraud-related behavior. See, Goodman v. De Azoulay, 539 F.Supp. 10 (E.D.Pa. 1981).

The jury acquitted petitioner of concocting a scheme to defraud. See United States v. Scott, 701 F.2d 1340, 1344 (11 Cir. 1983) (Representations known by a person to be false is a type of scheme to defraud). Therefore, there is no evidentiary basis in the record for the conclusion that petitioner had any intent to deceive. Thus, the utilization report must be analyzed for a determination as to whether it was false in the abstract. It was established at trial both through the government's witnesses and petitioner's case that petitioner utilized the value as opposed to cost concept on the advice of counsel that such a concept was consistent with his legal responsibility. Good faith reliance on the advice of counsel negates fraudulent

intent where the attorney is given all the facts and specifically advises a course of conduct. **United States v. McLennan, 563 F.2d 943, 946 (9 Cir. 1977), cert. den. 435 U.S. 965 (1978). Cf. United States v. Miller, 658 F.2d 235, 237 (4 Cir. 1981)** (The reliance defense to a charge of making a false statement is designed to refute the Government's proof that defendant intended to commit the offense and the essential elements of the defense are full disclosure of pertinent facts to an expert and good faith reliance of the expert's advice). Contrary to the findings of the Third Circuit, we submit that petitioner adequately apprised counsel of the facts and justifiably relief on his advice.

So too, petitioner utilized the 14% cost of administration concept on the basis of the advice of an expert. Use of this concept, as well as the value concept, is an industry standard, undertaken by reputable carriers such as Blue Cross and Blue Shield. The government did not controvert expert testimony to this effect. Therefore, there was no basis for a finding that use of these concepts effected a falsity. Those

concepts were listed on the face of the utilization reports. Since the reports did not mask use of these concepts, there can be no finding of falsity.

We stress that the utilization report at issue clearly indicates that value concepts are utilized. Moreover, the first utilization report identified the 14% cost of administration formula. The April 9, 1981 report subsequently filed was prepared in the same fashion. The report could only be found to be false if "value amounts" were deceptively described as "actual costs." No such deceptive packaging may be gleaned from an honest evaluation of the report. The report in no fashion tended to induce a reliance on the value amounts as representing costs. See, **United States v. Chapman**, 591 F.2d 1287, 1288 (9 Cir. 1979). We stress that when an inquiry was made, petitioner immediately stated that the reports were prepared on the basis of value amounts. This admission was made without hesitance or qualification. See, **United States v. Schreiber**, 449 F.Supp. 856, 864 (W.D.Pa. 1978), aff'd 599 F.2d 534 (3 Cir. 1979). Cf. **United States v. Dothard**, 666 F.2d 498, 503 (11 Cir. 1982).

We submit that no evidence of a false statement was adduced at trial which is sufficient to underpin petitioner's conviction. No rational juror could have found a false statement or misrepresentation beyond a reasonable doubt within the report mentioned in Count Three. Accordingly, a commission of §1027 may not be affirmed on the basis of an alleged false statement.

B. There Was No Evidence Adduced At Trial That Petitioner Knowingly Concealed A Fact Which Was Required To Be Disclosed

To affirm the conviction on the basis of the second prong of §1027, viz. concealment, this Court must find sufficient evidence within the record of a "voluntary, conscious failure to disclose without grounds for believing that such nondisclosure is lawful or with reckless disregard for whether it is lawful." United States v. Tolkow, supra at 858. We submit that this standard is controlling as opposed to the Third Circuit's view that a mere failure to dislcose is sufficient. United States v. Martorano, supra at 66. Acting on the advice of counsel, subsequent to full disclosure of all the facts, petitioner advised the Fund trustees and administrator that it was his view that he had made

the full disclosure required by law. The trustees and administrator did not seek any aid from a judicial or other governmental agency in an attempt to secure the information, which they knew had not been disclosed. The administrator merely filed the 5500 forms without the information. Apparently, the Fund attorney did not recommend civil or administrative remedies.

In this evidentiary context, a §1027 violation is clearly not sufficiently proved to extend liability to petitioner for a "knowing and conscious concealment." The nature of the concealment in **United States v. Tolkow, supra**, is instructive herein. In **Tolkow**, a trustee failed to disclose a party-in-interest loan. Specifically, the defendant in **Tolkow** loaned union funds to a company in which he (defendant) acquired a 50% interest. Party-in-interest loans were clearly required to be disclosed and defendant's purpose in concealing the loan was obvious. One of the specific purposes of enactment of the disclosure laws was to "curb potential self-dealing...by requiring disclosure of [party-in-interest] loans and relationships in a fund's annual reports." **United States v. Tolkow, supra at 855.**

In the instant case, petitioner was not detected in a concealment posture which amounted to violation of a fiduciary duty such as that in **Tolkow.** Petitioner refused to disclose his actual costs and profits. He was not the fiduciary of union funds. Upon transfer of the premiums to him, he became liable as a matter of contract law to provide services. See, **United States Department of Labor Pension Reform Guidelines (October 9, 1975 and January 13, 1970), Reg.Sec.2509.75-8, para.80,074.** Absent proof of a kickback to a trustee or other Fund fiduciary, the premiums bear no relationship to the fiduciary responsibility of any person. Accordingly, it was absolutely reasonable to rely upon the advice of counsel in refusing to disclose profits. Good faith reliance upon the belief that no additional disclosure was mandated negates the knowledge requirement. Thus, petitioner did not violate the statute notwithstanding that the Fund may have been entitled to his actual costs. In sum, there is no evidentiary predicate to support the instant conviction of petitioner .

CONCLUSION

For the foregoing reasons, we respectfully request that this Court grant certiorari.

Respectfully submitted,

s/R.M.B.

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Attorney For Petitioner

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Alan Dexter Bowman

Of Counsel and On the Petition

APPENDIX

Library References

United States ⇐121. C.J.S. United States §§ 168 to 172.

§ 1027. False statements and concealment of facts in relation to documents required by the Employee Retirement Income Security Act of 1974

Whoever, in any document required by title I of the Employee Retirement Income Security Act of 1974 (as amended from time to time) to be published, or kept as part of the records of any employee welfare benefit plan or employee pension benefit plan, or certified to the administrator of any such plan, makes any false statement or representation of fact, knowing it to be false, or knowingly conceals, covers up, or fails to disclose any fact the disclosure of which is required by such title or is necessary to verify, explain, clarify or check for accuracy and completeness any report required by such title to be published or any information required by such title to be certified, shall be fined not more than $10,000, or imprisoned not more than five years, or both.

Added Pub.L. 87–420, § 17(c), Mar. 20, 1962, 76 Stat. 42, and amended Pub.L. 93–406, Title I, § 111(a)(2)(B)(i), (ii), Sept. 2, 1974, 88 Stat. 851.

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 84-1511

UNITED STATES OF AMERICA

vs.

MARTORANO, JOHN,

Appellant

Appeal from the United States
District Court for the
Eastern District of Pennsylvania
(D.C. Crim. No. 84-00032)

Submitted Under Third Circuit Rule 12(6)
June 18, 1985
Before: ALDISERT, *Chief Judge*,
GIBBONS, *Circuit Judge*,
and DIAMOND, *District Judge*.*

(Filed July 8, 1985)

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OPINION OF THE COURT

PER CURIAM.

Section 1027 of Title 18 provides that it shall be a criminal offense to make a false statement in any document required by Title I of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*[1] The major question for decision

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1. . . 18 U.S.C. § 1027 provides:

> Whoever, in any document required by title I of the Employee Retirement Income Security Act of 1974 (as amended from time to time) to be published, or kept as part of the records of any employee welfare benefit plan or employee pension benefit plan, or certified to the admin istrator of any such plan, makes any false statement or representation of fact,

on this appeal is whether an understatement of profits by a health care organization that furnishes outpatient medical coverage to members of a health and welfare fund governed by ERISA constitutes a violation of the statute. The district court held that it does. *See* 596 F. Supp. 621 (E.D. Pa. 1984). We affirm.

I.

Teamsters Local 837 Health and Welfare Fund provides benefits, including health services, for members of Local 837 of the International Brotherhood of Teamsters. In September 1978, the Fund contracted with AMMA Health Center, Inc. to provide outpatient medical coverage to union members and their families. Appellant Martorano is the administrator and principal owner of AMMA.

In response to the Fund's request, on February 17, 1981, appellant provided the Fund with a "utilization report" that detailed the frequency with which union members utilized AMMA's services and the costs associated therewith. Appellant submitted a second report on April 9, 1981. The Fund needed these utilization reports to complete "5500 forms" for the Department of Labor, as required by ERISA.

Rather than providing the actual cost of services, appellant phrased his reports in terms of the "dollar value" of services used. Appellant calculated these dollar values by estimating how much the medical services provided would cost based on a Blue Shield

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knowing it to be false, or knowingly conceals, covers up, or fails to disclose any fact the disclosure of which is required by such title or is necessary to verify, explain, clarify or check for accuracy and completeness any report required by such title to be published or any information required by such title to be certified, shall be fined not more than $10,000, or imprisoned not more than five years, or both.

summarization of charges. Appellant then arrived at an "annual net profit" by subtracting the total dollar value of services plus the cost of administration from the amount of premiums paid by the Fund. The Fund's trustees and administrator, however, understood these reports to reflect AMMA's actual costs and actual profit. The Fund granted a premium increase to AMMA based on appellant's explanation that AMMA was losing money, an explanation confirmed by the utilization reports appellant submitted. A subsequent Pennsylvania state investigation revealed that the utilization reports significantly understated AMMA's profits, by as much as $47,000. Brief for the Appellee AT 9.

Martorano was indicted and convicted for violating § 1027 on the basis that the utilization reports contained false statements in ERISA documents. On appeal he argues that the conviction is invalid because § 1027 does not apply to medical service providers, but only to fiduciaries of union pension and welfare funds. Because our examination of the requirements of § 1027 involves the interpretation and application of legal precepts, our review is plenary. *Universal Minerals, Inc. v. C.A. Hughes & Co.*, 669 F.2d 98, 101-02 (3d Cir. 1981).

II.

In *United States v. S & Vee Cartage Co.*, 704 F.2d 914 (6th Cir.), *cert. denied*, 104 S.Ct. 343 (1983), the court considered whether § 1027 applied to an employer. Section 1027 provides that "whoever" makes false statements or conceals facts shall be fined or imprisoned. The Sixth Circuit interpreted the use of the term "whoever" as "clearly . . . sufficiently broad to include employers as well as fiduciaries." *Id.* at 917. *Cf. United States v. Nardello*, 393 U.S. 286, 292-93 (1969)(giving broad construction to the term

"whoever" in Travel Act, 18 U.S.C. § 1952). In addition, the court made reference to the legislative history of ERISA's provision precurser, the Welfare and Pension Plans Disclosure Act (WPPDA) and noted that criminal statutes, including § 1027, have been amended to refer to ERISA. The goal of the WPPDA was to "protect the [plans'] participants and beneficiaries . . . by requiring the plan to disclose and report financial information." 704 F.2d at 918. The court determined that extending liability to employers promoted that goal. *Id.*

We are satisfied with the reasoning of the Court of Appeals of the Sixth Circuit in *S & Vee Cartage Co.* and conclude that it is appropriate to apply § 1027 to appellant's activity. The statutory language is clearly broad enough to cover medical service providers. Moreover, subjecting appellant to the reach of § 1027 would promote the goals of ERISA. If medical service providers are not sanctioned for providing false information, plan participants will suffer.

We believe that the major limitation on the reach of § 1027 is that the false statements must be contained in documents required by ERISA "to be published, or kept as part of the records of any employee welfare benefit plan or employee pension benefit plan, or certified to the administrator of any such plan . . . ." 18 U.S.C. § 1027. The record in this case supports the government's claim that the utilization reports were needed by the Fund's administrator to file the 5500 forms. Health and welfare benefit plans must file a 5500 form with the Department of Labor, which includes a summary of benefits paid by and expenses of an "insurance company, insurance service, or other similar organization" which sells or guarantees plan benefits. 29 U.S.C. § 1023(e). Appellant, who sold medical services to the Fund thus falls into this statutory category. Regulation 29 C.F.R. § 486.3(c) requires the fund to maintain information certified to

the administrator by insurance companies or similar organizations. Without the utilization reports, the Fund's health plan could not be monitored by the government. App. for Appellee at 76-77. Thus, appellant cannot exempt himself from the statute based on the claim that the documents he submitted to the Fund were not covered by § 1027.

III.

We have also considered other contentions raised by appellant. We conclude that his conviction on this ERISA count is not inconsistent with his acquittal on another § 1027 count and a mail fraud count. *See United States v. Powell*, ___ U.S. ___, ___ (53 U.S.L.W. 4012, 4015, Dec. 10, 1984). We also conclude that a general intent (a failure to disclose) rather than a specific intent (a failure to disclose knowing that such failure violates a statutory disclosure requirement) is all that is required to prove a violation of § 1027. *See S & Vee Cartage Co.*, 704 F.2d at 919; *United States v. Tolkow*, 532 F.2d 853, 857-59 (2d Cir. 1976)(WPPDA case).

Appellant next argues that he made no false statements nor concealed facts. The record clearly discloses that appellant understated his profits and administrative expenses in the utilization reports. His use of the system of reporting "dollar value of services" and "annual net profit" permitted him to disguise where and how the Fund's premiums were being spent. Appellant accomplished this concealment by inducing the Fund's trustees and administrator to believe he was providing the Fund with actual costs and expenditures. App. for Appellant at DA85-86; DA90.

Appellant maintains that because he relied on the good faith advice of his attorney that he need not disclose his actual profits and expenditures, the evidence does not support the jury's conclusion that he

intended to conceal facts or make false statements. Appellant, however, cannot fulfill the requirements of this particular defense. Such a defense based on good faith reliance on an attorney's advice requires full disclosure to counsel of all material facts and retention of counsel for advice and not to ensure the success of the fraudulent scheme. *See United States v. Carr*, 740 F.2d 339, 347 (5th Cir. 1984). Appellant neither fully disclosed the nature of the utilization reports, app. for appllee at 117-18, nor did he rely on his attorney's advice. He told his attorney what position to argue before the Fund, and his attorney confirmed that position was acceptable. *Id.* at 98, 111.

A final argument concerned an alleged error in a supplemental jury instruction. Following a remand on May 20, 1985 by this court pursuant to Rule 10(e), Federal Rules of Appellate Procedure, the district court concluded that the record supplied this court on appeal contained a typographical error. We hold that the record, as now corrected in accordance with the district court's order of June 11, 1985, does not indicate an error in the court's charge.

IV.

The judgment of the district court will be affirmed.

A True Copy:

Teste:

Clerk of the United States Court of Appeals
for the Third Circuit